treatment is instituted in the early stages. The treatment recommended by him consists in the employment of warm compresses and inunctions of green soap, together with the administration of creosote carbonate, the action of which is as favorable in tuberculosis of the mesenteric glands as in analogous inflammations of the cervical and brachial glands. A child of ten years may receive from 5 to 10 drops three times a day.—*Die Therapie der Gegenwart*, 1905, No. 4, p. 108.

OBSTETRICS.

UNDER THE CHARGE OF

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Sudden Death during or Immediately after the Termination of Pregnancy or Operation on the Pelvic Organs in Women.—At the last meeting of the American Gynecological Society, Davis (*Surgery, Gynecology, and Obstetrics*, July, 1905) reports 3 cases of sudden death; 1 after abortion, 1 after delivery by forceps, and 1 after hysterectomy with the removal of the tubes and ovaries.

The case of abortion had been criminal, and the patient was seen in consultation some time afterward with a retained placenta. This was removed under ether, the uterus irrigated and packed. The patient died during operation, and autopsy revealed no cause.

A primipara who had been subjected to great mental strain during pregnancy had also suffered from grip with chronic bronchial catarrh; elimination had been badly performed. Fourteen hours after the first sign of labor, while the patient was in good condition, the fetus had descended to the pelvic floor and rotation was partially complete; the patient complained of suffering, and took 4½ ounces of Squibb's ether from a freshly opened can, administered by dropping upon gauze. The pulse did not rise over 90 and was of good quality. Shortly after the delivery of a large male child by forceps and the removal of the placenta, the patient had a respiratory spasm with persistent action of the heart. Forty-five minutes after this respiratory failure was complete and cardiac failure ten minutes later. An autopsy could not be obtained, but the symptoms were those of pulmonary embolism.

His third case was that of a neurotic woman, who, some years previously, had a difficult labor with infection and lacerations. During a rest cure she was taken with thrombosis of the left lower extremity, with nephritis and pelvic peritonitis; thrombosis also extended to the right side. From this the patient recovered in two months, and was then in good general condition. She requested operation to avoid the danger of repeated attacks.

On opening the abdomen some adhesions between the uterus and surrounding tissues were broken up; there were evidences of previous infection on the left side of the uterus; the ovaries were cystic, and the tubes showed evidence of chronic infection. The body of the uterus, tubes, and ovaries were removed without hemorrhage and shock. The patient developed rapid pulse after the operation, but improved. Forty-eight hours after operation she died suddenly on awaking from sleep. On autopsy pulmonary embolism was present and had caused death.

In 18,800 women in childbirth or after operation, 30 cases of immediate pulmonary embolism were reported, with a mortality of 73.33 per cent.

Pulmonary embolism may also be secondary to a primary thrombosis; this is not unusual, and is frequently preceded by a progressively rapid pulse, while the temperature of the patient may fall to normal. This rapid pulse, known as Mahler's sign, was present in 63.33 per cent. of cases.

Regarding the causation of immediate pulmonary embolism, no satisfactory explanation can be given which can be traced to any one manipulation, nor to any one stage of labor. Those patients who have had pulmonary infections during pregnancy or who have had disease of the bloodvessels before labor or operation are most liable to its development. The most severe cases of labor frequently escape death in this form.

So far as the treatment of pulmonary embolism goes, it consists in putting the patient at absolute rest and giving stimulants promptly. Where thrombosis precedes, much can be done to avoid the accident by keeping the patient perfectly quiet.

The author, from cases reported in 193 papers, aggregating 125 cases, compiled a table of 25 typical cases, which is appended to the original paper.

Intrauterine Movements of the Thorax and the Diaphragm. Intrauterine Breathing.—AHLFELD (*Monatsschrift für Geburtshülfe und Gynäkologie*, 1905, Band xxi., Heft 2) describes what he terms intrauterine fetal breathing. He finds mention of this by several authors in the literature of obstetrics.

Personally he has repeatedly observed upon inspecting the abdomen of a woman in the last months of pregnancy, and by practising palpation, not only the usual movements of the lower extremities and the trunk, but also an involvement of the fetal thorax, which is not to be confused with the aortic pulse of the mother. This fetal movement is wave-like in character, and, when a tracing of it is taken, it resembles that of the respiratory movements in the newborn child. These movements occur frequently at regular periods, followed by a short pause. These movements vary in number from 38 to 76 in the minute, making an average of 61. By comparing the curve of these fetal movements and that of the mother's aortic pulse, they are seen to be widely different in frequency and also in character. They may also be distinguished from the respiratory movements of the mother. They are readily recognized as distinct from her uterine contractions. If the newborn child when placed in a bath of warm water be closely watched, he performs similar thoracic movements. The relation existing between inspiration and expiration in the child after birth and the same phenomena in fetal respiratory movements are found to be almost identical. In some cases where the child lies in the uterus with the thorax anterior, these movements may be studied with especial clearness.

Evidently if the fœtus makes inspiratory movements while within the